WISCONSIN MEDICAID
PROVIDER CHANGE OF ADDRESS OR STATUS INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested may result in denial of Medicaid payment for those services.

INSTRUCTIONS

If a request is made to change an individual provider's file, Wisconsin Medicaid requires the individual provider's signature on the Wisconsin Medicaid Provider Change of Address or Status form. Signature stamps are not allowed.

Complete all areas of the form affected by change. A change in ownership, group affiliation, federal tax identification number (Internal Revenue Service [IRS] number), etc., must be reported to Wisconsin Medicaid *before* the change. A change in address must be reported immediately after moving.

SECTION I — PROVIDER INFORMATION

The information in this section pertains to the provider who performs Medicaid services and the location where the services are performed. Wisconsin Medicaid mails provider publications to this address.

Name — Provider

This is a required field. Enter the individual provider's first name, middle initial, and last name, or the name of the clinic or facility.

Name — Contact Person

If the contact person is different from the provider, enter his or her first name, middle initial, and last name here.

Wisconsin Medicaid Provider Number

This is a required field. Enter the provider's eight-digit Medicaid identification number. Do not enter any other numbers or letters. The provider number given must match the provider name listed in this section.

Medicare Provider Number

This is an optional field as some providers do not have a Medicare identification number. Enter the provider's Medicare identification number for the same services billed under the Wisconsin Medicaid number (i.e., hospital, physician clinic, and home health.) Providers without a Medicare identification number do not need to complete this field.

Attention

Enter the complete name of the person or department (i.e., billing) to whom provider publications should be directed.

Telephone Number — Provider

This is a required field. Enter the provider's telephone number, including the area code.

Street Address — Provider

Enter the provider's complete physical work address (street, city, state, and ZIP code). This address is the location where services are primarily provided. If the address is a rural route, indicate the fire number and directions to the provider's physical location in the space below the address field. A post office (P.O.) box number alone is *not* acceptable.

SECTION II — PAYEE AND TAX INFORMATION

Wisconsin Medicaid mails reimbursement checks and Remittance and Status (R/S) Reports to the address listed in this section.

Name — Payee

Enter the payee's first name, middle initial, and last name, or the name of the office, clinic, facility, or place of business. The payee name could be the same as the provider name listed in Section I but do not write "same" in this field.

Attention

Enter the complete name of the person or department (i.e., billing) where reimbursement checks and R/S Reports should be directed.

Address — Payee

Enter the payee's complete address (street, city, state, and ZIP code). The payee address could be the same as the one listed in Section I. A P.O. Box number alone *is* acceptable.

IRS Number — Payee

Enter the payee's IRS number. The IRS number listed must belong to the payee name provided in order to match IRS files. If the payee's name changes, the IRS number must be provided. (The IRS number may either be an Employee Identification Number, or for individuals, a Social Security number.)

IRS Number Effective Date

Enter the date (MM/DD/YYYY) that the IRS number became effective.

Signature — Provider

The provider's signature is *always required* on all requests to change the provider file. The provider's signature (first name, middle initial, and last name) must appear here. Signature stamps and electronic signatures are not acceptable.

Date Signed

This is a required field. Enter the month, day, and year (in MM/DD/YYYY format) this form was completed and signed.